

Nursing Policy Research

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*Turning Evidence-Based
Research Into Health Policy*

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Editors

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Contents

List of Figures xiii
List of Tables xv
Contributors xvii
Foreword by Linda Aiken xix
Preface by Geri L. Dickson and Linda Flynn xxiii
Acknowledgments xxvii

SECTION I: DISCOVERING THE RESEARCH TO POLICY CONNECTION 1

1 Back to the Future: From Evidence to Policy 3
Gerl L. Dickson
Select Examples of Past Policy Changes 4
Where Do We Go From Here? The Intersection of Politics
and Policy 12
Applying Kingdon and Gladwell's Theories to Policy Change
by Nurses 16

**2 Nursing Outcomes Research: Connections to Workforce Issues
and Policy Decisions 19**
Sean P. Clarke
Health Services Research and Nursing Outcomes Research 20
Challenges in Nursing Outcomes Research 22
Nursing Outcomes Research at the University
of Pennsylvania's Center for Health Outcomes
and Policy Research 27
The Future and the Role of Nursing Outcomes Research 29

Lessons Learned 33
Gerl L. Dickson

SECTION II: TOWARD EVIDENCE-BASED POLICY: COLLECTING AND MANAGING THE DATA 39

Introduction 39

Geri L. Dickson

3 Addressing the Complexities of Survey Research 43

Patricia Moulton, Linda M. Lacey, Linda Flynn, Christine Tassone Kovner, and Carol S. Brewer

It Is All About the Why: Determining Your Survey Research Topic 44

Do You Know What You Are Asking? Common Problems With Survey Questions 50

Mail Survey Method: Imperatives and Pitfalls 58

Collecting Data by Survey—The Best-Laid Plans Can Go Awry 62

4 Forecasting a State Supply and Demand of RNs Using the Revised 2005 HRSA Models 71

Lynn Unruh and Valerie Danesh

The HRSA Nursing Demand and Supply Models 73

Using the HRSA Models for Forecasting in Individual States: Three Approaches 81

FCN Experiences in Using the HRSA Models for Forecasting in Florida 85

Summary of FCN Experiences: Lessons Learned in Using the HRSA Models for Forecasting in Florida and Recommendations for Other States 98

5 Missing Data Effects on Nurse Workforce Analysis and Projections 103

Jennifer G. Nooney

Sources and Causes of Missing Data 104

Analyzing and Classifying Missingness: The Bias Analysis 107

Traditional Methods for Dealing with Missing Data 111

Recent Developments in Missing Data Techniques 115

Lessons Learned 121

Linda Flynn

SECTION III: RESEARCH AND WORKPLACE POLICY 125

Introduction 125

Geri L. Dickson**6 Work Satisfaction Among Staff Nurses in Acute Care Hospitals 127****Carol S. Brewer and Christine Tassone Kovner**

Sample 128

Methods 129

Findings 130

Discussion 136

Policy Implications 138

**7 Workload, Quality of Care, and Job Satisfaction
in Home Health Nurses 143****Linda Flynn**

Background and Significance 144

Method 146

Findings 147

Policy Implications 150

8 The Emotional Demands of Nursing 155**Rebecca J. Erickson**

A Crisis in Nurse Staffing 156

Why Nurses Leave Direct Patient Care 157

The Emotional Foundations of Burnout 158

Methods 162

Results 168

What Influences Burnout Among Registered Nurses? 170

Which Facets of the Emotional Context of Care Might Contribute to an
Understanding of Burnout Over and Above the Effect of Individual
and Occupational Characteristics? 172

Lessons Learned 179

Geri L. Dickson**SECTION IV: RESEARCH AND EDUCATIONAL POLICY 183**

Introduction 183

Geri L. Dickson

9 Nursing's Long-Term Pipeline: A Study of High School Students Using a Unique Data Collection Approach 187

Rebecca Rudel and Patricia Moulton

- North Dakota's Unique Nursing Education History 188
- Tomorrow's Nursing Pipeline: A Literature Review 191
- Nursing as a Specific Career Vision in High School 193
- The High School Student Survey 194
- Discussion 200

10 The Looming Crisis of an Inadequate Pipeline for Nursing Faculty 209

Brenda Cleary, James W. Bevill Jr., Linda M. Lacey, and Jennifer G. Nooney

- Faculty Supply and Demand 210
- The Pipeline for Faculty Roles 212
- Discussion 214

11 Clinical Simulation and the Need for Evidence-Based Policy 219

Felissa R. Lashley and Wendy Nehring

- Types of Simulation 221
- Standardized Patients 225
- Simulation and Policy 226

Lessons Learned 233

Geri L. Dickson

SECTION V: FUNDING THE RESEARCH TO POLICY CONNECTION 237

Introduction 237

Linda Flynn

12 Of Horses and Ponies: Taking Your Show to Washington 239

Claudia L. McDonald

- Why Should I Learn to Dance? 239
- The Dance: One Step at a Time 242
- The Federal Budget Process 246

13 AHRQ Funding Opportunities for Nurse Researchers 253**Kathleen Kendrick, Gail S. Makulowich, and Mary L. Grady**

- AHRQ's Changing Mission 254
- AHRQ's Research Priorities 255
- Research Funding Opportunities 257
- Training and Career Development Programs 263
- Research Infrastructure Support Programs 265
- Getting an AHRQ Research Grant 266
- Overview of the Grant Application Submission, Review,
and Award Process 267

**14 From Issues to Action: How the Robert Wood Johnson
Foundation Influences Health Policy 271****Lori Melichar and Susan B. Hassmiller**

- Governmental Policy: RWJF's Role in Advancing the Nurse
Practitioner Role 272
- Organizational Policy: Transforming Care at the Bedside 273
- The Process of Influencing Policy 275
- Identifying Promising Solutions to Improve Health
and Health Care 278
- Creating the Evidence to Convince Policy Makers to Improve
Health and Health Care Policy 279
- Restrictions on Lobbying: A Delicate Balance 285
- Building Capacity of Individuals and Institutions 288
- Conclusion: How RWJF Influences Policy 289

**15 A Metaphor for Addressing the Nurse Shortage
in Oregon 293****Judith L. Woodruff**

- Northwest Health Foundation 294
- Farming and the Relationship to the Nursing
Workforce Crisis 295
- Cultivating the Environment for Nursing 296
- Planning for Future Crops: Supporting a Nursing
Policy Agenda 308
- Conclusion and Key Findings 310

Lessons Learned 313**Linda Flynn**

SECTION VI: MAKING THE RESEARCH TO POLICY CONNECTION 317

Introduction 317

Geri L. Dickson

16 Policy Development and Nursing 319

Lucille A. Joel

Citizenship in a Democracy 319

Nurses as Participants in a Democratic Community 320

The Power of Numbers 322

Politics for Policy 323

Beyond Baseline 327

**17 State Funding for Nurse Faculty Loan Repayment:
The Vermont Experience 329**

Mary Val Palumbo

Applying Kingdon's Framework 329

The Political Stream 333

The Policy Stream 333

**18 Using Research to Influence Federal Policy:
The Nephrology Nurses' Experience 343**

**Linda Flynn, Charlotte Thomas-Hawkins,
and Sandra M. Bodin**

The Research–Policy Connection 344

The Revised Model in Action 344

Lessons Learned 349

Linda Flynn

EPILOGUE 353

19 From Research to Policy—The Ultimate Translation 355

Linda Flynn and Geri L. Dickson

Index 359

List of Figures

CHAPTER 2

Figure 2.1 Nurse Practice Environments, Nurse Staffing, and Outcomes 25

CHAPTER 4

Figure 4.1 Overview of the NDM 75

Figure 4.2 NDM Operational Structure 78

Figure 4.3 Overview of the NSM 79

Figure 4.4 NSM Operational Structure 80

CHAPTER 5

Figure 5.1 Projected RN FTE Growth in NC Hospitals, 2004–2006 117

CHAPTER 8

Figure 8.1 Percentage Reporting Emotional Context-of-Care Experiences 169

Figure 8.2 Job Burnout Regressed on Emotional Experience 171

Figure 8.3 Job Burnout Regressed on Emotional Labor 171

CHAPTER 9

Figure 9.1 Reasons for Not Planning for a Nursing Career 197

Figure 9.2 Students' Agreement With Perception Statements 198

CHAPTER 10

- Figure 10.1** Projected Faculty Supply and Demand Under Different Retirement Thresholds and Student-to-Faculty Ratios 210

CHAPTER 12

- Figure 12.1** Overview of the Federal Budget Process 248
Figure 12.2 Focus on the Congressional Budget Process 249

CHAPTER 13

- Figure 13.1** Supply-side Research Paradigm 256

List of Tables

CHAPTER 4

- Table 4.1** HRSA NDM Projections: Nurse Types and Health Care Utilization by Setting 76
- Table 4.2** Summary of Data Sources and Corresponding Data Fields 87
- Table 4.3** Baseline Comparisons of Employed Florida Nurse FTEs: HRSA Versus FCN Numbers 92
- Table 4.4** Baseline Comparisons of Florida RN Populations: HRSA Versus FCN 93
- Table 4.5** Baseline Comparisons of Florida RN New Graduates and Educational Upgrades: HRSA Versus FCN Values 94

CHAPTER 5

- Table 5.1** Hospital Size and Response Status 109

CHAPTER 6

- Table 6.1** Predictors of Job Satisfaction 135

CHAPTER 7

- Table 7.1** Sample Characteristics ($n = 137$) 146
- Table 7.2** Correlational Coefficients of Workload Variables and Quality Indicators ($n = 137$) 149
- Table 7.3** Odds Ratios Associated With Unadjusted Effects of Workload and Quality Indicators on Home Health Nurses' Intentions to Leave their Jobs 149

CHAPTER 10

Table 10.1 Percentage of Cohort Members Achieving Master's and
Doctoral Preparation 215

CHAPTER 17

Table 17.1 All Options Considered 335

Table 17.2 A Summary of all the Legislation that was Introduced for
Nursing Faculty Loan Repayment in Vermont 340

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James W. Bevill, Jr., MSN, RN

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Foreword

More than 150 years ago, Florence Nightingale inalterably influenced the evolution of the modern hospital and the establishment of the profession of nursing through outcomes research. Nightingale meticulously used statistics to demonstrate to British officials that more soldiers in the Crimean War died because of unsafe care environments in military hospitals than of wounds received in battle. She then demonstrated a dramatic reduction in deaths following the introduction of nurses whose roles included making the care environment safer (Cohen, 1984). Despite such an auspicious beginning, nursing policy research is still in its formative phases, having experienced little development between Nightingale's research and the late 20th century.

There are lessons from Nightingale's research that can guide the further development of policy-relevant research concerning nursing. First, her topic, preventable deaths in government institutions, was a problem that military and government representatives had already identified as needing attention. Policy research is more likely to have impact if framed in the context of a social problem that policymakers or health care leaders have already agreed is necessary to address. Policy research on problems that have not risen to visibility on the public's agenda is much less likely to have an impact on change, even if the research is carefully designed and implemented. Thus, the first step in successful policy research is the identification of a problem to which policy makers are seeking solutions. This requires nurse researchers to read the broad health policy literature including the mass media and to have collaborators from other disciplines whose knowledge base is different from nursing. Therefore, a fundamental requirement of successful policy research is an interdisciplinary team.

A second lesson from Nightingale's research is presentation of research findings so that they can be easily understood by an informed general audience. Nightingale's innovative charts created a form of communication

that could be understood without knowing statistics. Of course, social statistics were just evolving in Nightingale's time; indeed she is credited with having a major role in the development of proportional statistics. Today we have often-conflicting requirements: the demands of peer reviewers and editors of scientific journals for the use of complex statistical presentations of findings versus the need for readability and simplicity of research design and presentation of results to communicate with those who can actually implement the findings by changing practice and policy.

Balancing the competing demands for complexity and simplicity is one of the great challenges of policy research. The challenge is made even more difficult by the power of stakeholders in political discourse who tend to refute inconvenient research findings by attempting to discredit the scientific legitimacy of the research rather than debating the practice and policy implications of research findings they do not like. This leads experienced policy researchers to "defensive practices" involving the use of complex research designs and methods that then become difficult to explain clearly. Stakeholders need only to confuse policy makers with research rhetoric, not necessarily disprove findings that run counter to their interests. Sometimes third-party neutral research organizations such as the Institute of Medicine or the New York Academy of Medicine can be helpful in interpreting evidence from competing points of view. In the end, however, nothing is as effective in influencing policy as clear answers to important questions gained through powerful but simple research designs.

In the chapters that follow, experienced policy researchers address how to manage multiple challenges to successfully make the transition from statistical significance to policy. Policy research shares with all forms of research the requirement for scientific rigor and clearly presented results. Usually the best research in any field is elegant in its simplicity and clarity. However, policy research often requires more front-end investment in the selection of the research question and its framing in a policy-relevant context than do disciplines where the primary audience is other researchers who together are trying to advance knowledge through cumulative research contributions. As well, significantly more investment is required in translating the findings of policy-relevant research to audiences who are not scientists.

Despite the difficulty of policy research, there is nothing as thrilling as seeing the results from rigorously designed research translated into public policies that benefit millions of people. Nursing has solutions to

many of the most challenging issues in health care. Policy research is a vehicle to promote the widespread adoption of effective nursing solutions for the benefit of the public and for the continued advancement of the nursing profession.

Linda H. Aiken, PhD, RN, FAAN

REFERENCE

Cohen, I. B. (1984). Florence Nightingale. *Scientific American*, 250, 128–138.

Preface

A reoccurring theme among the chapters of this book centers on the powerful potential of nursing research to influence health policy decisions and initiatives. Additionally, the benefits of evidence-based policies, informed by findings from the scientific analyses of real-world observations compared to a “best guess,” are similarly highlighted.

Throughout the book, contributors share their knowledge, skills, and experiences related to various aspects of the research enterprise and its impact on the research to policy connection. The foci of their respective research agendas frequently include nurse workforce issues, nurses’ work environments, and the nature and outcomes of nurses’ work. Consequently, these chapters may be of particular interest to leaders, researchers, and evaluators engaged in nursing workforce issues and nursing outcomes research.

Yet the principles and processes related to policy-influencing research, as shared throughout these chapters, transcend specific investigative agendas. Whether your interests are in maternal–child health, vulnerable populations, cardiac care, mental health disorders, or any population, health risk, or disease state, the use of research findings in the development of evidence-based policy decisions is, likewise, imperative. Toward that end, the chapters offered throughout the book have been designed to inform activities that may enhance your research to policy connection, regardless of your practice area or the nature of your research questions.

The book is divided into seven sections, and the editors have shared the responsibility of tying the chapters and sections together. Each section begins with an introduction and the theme of the section and concludes with a summary of the lessons learned from the studies in that section.

Section I is devoted to two introductory chapters: chapter 1 features a beginning of a dialogue of the research to policy connection, and chapter 2 presents an overview of nursing outcomes research and its

relationship to policy decisions. These suggest that evidence does not just “happen.” Instead, the production of trustworthy evidence requires a rigorous process and an ongoing refinement of research skills.

Toward that end, Section II offers “how to” chapters: three substantive chapters based on the experiences of seasoned researchers. The first, chapter 3, describes the processes and potential problems of collecting and managing data. A detailed description is found in chapter 4 of the procedures necessary to select, input, and analyze existing databases to project supply and demand for nurses on a state level, using the standardized national supply and demand models. Chapter 5 focuses on a problem that plagues most survey researchers—missing data. The author details methods of imputing data into survey research and describes the effects of missing data. All of these methods, however, are relevant to surveys of other topics.

Section III is devoted to research and workplace policy, with chapter 6 focusing on a study of work satisfaction among nurses in acute care hospitals. The findings from this regional study of RNs provide strong evidence for the authors’ recommendations for policy changes.

The section continues in chapter 7 with the report of a national study of home health nurses and stresses the findings of the relationships of workload, quality of care, and job satisfaction for nurses in community settings. The author submits potential policy changes based on her findings. Chapter 8 concludes this section with a study based on statistics and the words of nurses about the emotional labor of nurses in hospitals. This author also puts forth evidence-based recommendations for policy changes aimed at retaining nurses in the workplace.

Section IV focuses on research and educational policy. In chapter 9, two North Dakota researchers report on their online survey of high school students in North Dakota and the students’ perspectives on nursing as a career. Particularly interesting is the context of the study—the repeal of the North Dakota legislative mandate for two levels of licensure. North Dakota was the only state to implement that position, advocated by the 1965 American Nurses Association’s position statement on nurse education.

In chapter 10, a team from the North Carolina Center for Nursing, the first state nursing workforce center, projects the future supply of faculty based on potential retirements of current North Carolina faculty. They present scenarios demonstrating reduction in the projected faculty shortage resulting from a staged increase in the student-to-clinical faculty ratios. Rounding out this section is chapter 11, in which experts in the field present discourse about the use of simulation models in nurse

education. The authors, well known for their studies in this area, present the research suggesting pros and cons of simulation clinical education and the regulatory changes that may be necessary.

Section V presents critical information about securing funding for your research. In chapter 12, we find a description of how to seek funding through the U.S. Congress to obtain federal grants for your state research work. In chapter 13, colleagues from the Agency for Healthcare Research and Quality (AHRQ) describe their agency's mission and goals. They offer examples of funded nurse research, tips for writing proposals, and common problems to avoid in order to obtain AHRQ funding for your research.

In the succeeding chapter, officers from the Robert Wood Johnson Foundation delineate the impact of this national foundation and the grants they make to provide evidence that can influence policy in the United States. The foundation has devoted a good share of its philanthropic mission to nursing grants. In chapter 15, an officer in the Northwest Health Foundation takes a state perspective that outlines its role as a local foundation in funding grants to address workforce issues in Oregon. She views the nurse workforce as a living system and convincingly uses the metaphor of "farming" for the foundation's active role in sustaining state grants to address the local nurse shortage issues.

Last, but certainly not least, is the section on making the research to policy connection, offering suggestions and examples of how to make that policy connection. Chapter 16 lays out how *nurses as citizens* of health care can use their expertise in work settings, professional organizations, or public policy arenas to influence policy change. The following chapters offer examples of how nurse researchers have been able to make that research to policy connection. In chapter 17, the author carefully describes how nurse leaders in Vermont were able to make that connection, based on findings from the Vermont Office of Nursing Workforce. Collaborators in research in chapter 18 delineate the research, the political process, and the professional organization's strength they used to persuade the Centers for Medicare and Medicaid to adopt regulations mandating an RN be present during dialysis treatments.

The book concludes with an epilogue in which we address a means to carry out the ultimate research to policy connection—translation of research findings into policies. Thus, our research to policy journey concludes with an understandable framework from which to begin the process of connecting the research to the policy—an arduous and worthwhile venture!

Acknowledgments

Many of the chapters in this book began as presentations at the national conference for leaders in state workforce centers hosted by the New Jersey Collaborating Center for Nursing in 2006. Some of those presentations, together with additional authors, now provide a roadmap to identify how scientific, patient-oriented research is developed, administered, and presented and how it can drive many levels of policy change so that the health care system can achieve better, more cost-effective outcomes.

We gratefully acknowledge the philanthropy of the Robert Wood Johnson Foundation for their support of the conference and for continuing to fund the Jersey Collaborating Center (the Center). Making the Center a public/private venture, the state of New Jersey also has provided funding for the Center.

We extend an enthusiastic thanks to the authors who have shared their research, innovation, compassion, and talents with you, the readers of this book. Although most are nurse researchers, five of the authors are non-nurses, indicating the value of interdisciplinary collaboration.

We also want to acknowledge the fine technical assistance in the preparation of this book by Allison Creary and Mary Ellen Cook. Further, this book would not have been possible without the continuing support and love of our husbands: Carlisle Dickson and Roger Flynn.

A special thanks to the editors of Springer Publishing, whose helpful consultation has enabled us to achieve our goal to fill an educational void. They have helped us to put a useful resource into the hands of graduate students.

And finally, to the students who are studying how to ensure that nursing will be at the table when key health care policy decisions are made—we invite you to learn the skills and to build on the strong legacy of history's nursing leaders and researchers for the benefit of your patients.

Discovering the
Research to Policy
Connection

SECTION
I

1

Back to the Future: From Evidence to Policy

GERI L. DICKSON

We who are nurses are inheritors of a great tradition. It is ours to guard, to strengthen, to enlarge where needed, and to equip ourselves worthily for so doing.

—M. Adelaide Nutting (1939)

As we embark on our journey of discovering the research to policy connection, this chapter provides an introduction for the ongoing journey. How far has nursing come in terms of providing evidence as the basis for policy change? Where are we today in that journey toward creating change through clinical, organizational, educational, professional, and public policy? As Aiken points out in this book's foreword, Florence Nightingale led the way in introducing the idea of quantifying and displaying data linking the work of nurses to the soldiers' survival during the Crimean War. This is part of the great tradition that we, as nurses, have inherited.

Nightingale developed and used her coxcomb diagrams, which are credited with having spawned the use of pie charts, to identify the differences nurses' care made in the lives of British soldiers during the 1854–1856 Crimean war. However, what was most unusual and unique was how she presented her data to demonstrate the number of *preventable* soldier deaths before and after the advent of nurses' care. Trained nurses, indeed, did make a quantifiable difference in the lives of the British soldiers.

Accordingly, the death rate of soldiers, resulting from disease and infections, decreased from 47% before the introduction of trained nurses to 2% after their arrival (Florence Nightingale Museum, 1854–1856). Nightingale used her evidence to support a sea change in nursing by identifying a problem—the lack of nursing care—around which the public, interest groups, media, and others could rally. She provided the evidence for a policy change in 1860 that has had an impact on health care ever since—the first organized program of training for nurses.

Over the last 150 years, and despite an increase in nursing research, policy questions have seldom been the major foci of research. As the twentieth century drew to a close, nurse researchers began to return to Nightingale's use of statistics to demonstrate with empiric evidence the differences nurses' care made in the lives of their patients. In time, clinical and patient outcomes research began the connection to policy-oriented change.

In this chapter, I provide a historical context for this book, citing select examples of how policy created by others has changed nursing and how some nurses, even without empirical evidence, were able to create policy changes. The policy changes are framed from a perspective of the merging of a policy agenda (Kingdon, 2003) and the support of others to fill a societal need, thereby creating a window of opportunity in which change can occur. From this perspective on the past and present of nursing policy development, an important question for the future is considered: how might we best move forward to translate our knowledge and evidence into policy changes that will improve the health of our nation's citizens?

SELECT EXAMPLES OF PAST POLICY CHANGES

The Formation of Nursing Schools

Because of the public's appreciation for Nightingale's work, a public trust was established that financed the Nightingale Training School for Nurses as an entirely independent educational institution. St. Thomas Hospital in London was chosen as the site of the school, but not without opposition from most physicians, who did not support the idea of any teaching for nurses beyond the "how to" of poultice-making (Donahue, 1985). Nevertheless, the public, the media, and the politicians of the day all supported Nightingale and her work. Consequently, the school thrived

and became extremely important to nursing's future as a profession—a change made by virtue of evidence and social need.

Although there were no formal training programs in the United States, the Civil War, just like the Crimean War, brought the need for nursing care to others' attention. As the 19th century wore on, a growing sense of social responsibility for citizens' health in the United States contributed to the recognized need for formal training for nurses (Grippando, 1977). Accordingly, in 1873 three U.S. schools of nursing were started, based on the Nightingale system of nurse education. However, the schools in the United States, contrary to Nightingale's model, were not independent in financing or infrastructure; they were placed under the jurisdiction of the hospital and medical staff (Kalisch & Kalisch, 1986).

The Public Health Movement

As the 19th century drew to a close, social responsibility for health increased, and public health gained a new emphasis. Nurse leaders such as Lillian Wald rose to the occasion and demonstrated the value of nurses to provide care to the community and to advance public health. Although the nurse leaders did not employ the use of empirical evidence, nurses were recognized by the public as valuable and were the forerunners of the Visiting Nurse Associations and, later, public school nursing.

Based on business and the private sector's belief in the value of nurses and health, the Metropolitan Life Insurance Company provided free home nursing to policyholders, helping to keep them well during the early 20th century. Other community nurses worked in organized efforts to improve maternal and child care. The focus was on new immigrants and their families and involved assessment of social conditions as well as health needs. In this new role and before the development of vaccines or medications, nurses managed major infectious diseases, such as tuberculosis, in the community. Additionally, improving family health in the rural and country areas of our nation became a focus of nurses' care in the early 20th century.

By 1910, the nurses working in the various communities formed the National Organization for Public Health Nursing. Lillian Wald became the first president, and the founders of the organization declared that “the experience data available emphasized the urgency and practical necessity for the extension of public health nursing service to a much larger proportion of wage-earners and people of moderate means than now have the benefit of same” (Kalisch & Kalisch, 1986, p. 288). Indeed, infectious

diseases had decreased, but so many societal changes (e.g., improved water supply, sewage disposal, cleaner streets, and regulation of food and dairy products) were made that nurses could not take credit for all of the changes. Rather, they cited what people experienced as the basis for change. Nevertheless, public health nurses had the support of the public and business and made an important difference in people's lives—they filled a social and health need.

Impact of Scientific Medicine on Nursing

In the following decade, nurses remained busy starting schools of nursing, educating teachers of nursing, advocating for regulation through licensure of nurses, and taking care of the sick in patients' homes. The superintendent of nursing supervised both the school of nursing and the hospital. She and supervisors oversaw the students' clinical practice, and, of course, physicians taught many of the classes. The superintendent and a supervisor were generally the only graduate nurses in the hospital as the student nurses provided the care for the patients. Their care included domestic work, cooking meals, and keeping the wards warm and spotless, as well as caring for the patients' comfort and physical needs.

At the same time, physicians were organizing their own schools, but neither regulations nor standards were in place. In 1910, with a grant from the Carnegie Foundation, Abraham Flexner conducted a review of all 155 medical schools in the United States and Canada, ranking their quality and value (Flexner, 1910). The outgrowth of the Flexner Report was that medicine became a university discipline with strict standards of admission and hospital affiliations to achieve quality medical education, based on the scientific model in place at Johns Hopkins University.

However, nursing education remained hospital based; the students cared for the patients and kept the hospitals running. As a result, the atmosphere in the hospital nursing schools remained one in which the doctors were in charge. A sense of what it was like to be a student at this time can be found in the first verse of this poem written by an early hospital nursing student:

Nurses moving quietly,
Voices hushed in awe.
All things silent waiting.
Obedient to the law
That we have heard so often.

But I'll repeat once more:
"All things must be in order
When doctor's on the floor." (Kalisch & Kalisch, 1986, p. 216)

Nevertheless, the nursing leaders of the day saw this movement of medical education into the university as an opportunity for a Flexner-like report to be conducted to revamp nursing education. Although the Carnegie Foundation funded other educational reports—for example, dental, legal, and teacher education—the nurses' pleas were passively ignored (Kalisch & Kalisch, 1986). An educational policy shift designated the medical school as the sole center for the production of physicians, and the apprenticeship programs passed into history. At the same time, the reform also was successful in creating medicine as a profession almost exclusively for white, male, upper-class Americans, leaving out women and Blacks (Reissman, 1983). Try as they might, nurse educators never were able to move nurse education from the hospitals into universities and colleges. Even today, the bulk of nurse education is found in 2-year community colleges or hospital schools, with a smaller percentage of the total new nurses graduating from 4-year colleges and universities.

The Start of Higher Education for Nurses

The U.S. Children's Bureau was established in 1912, and the welfare of America's children became a matter of national concern (Worcester, 1914). The passing of the federal Sheppard-Towner Act of 1921 provided the states with federal grants-in-aid for services for the welfare and hygiene of mothers and children. These services were most often free to the participants, with the costs borne by the federal funding or, in some cases, by charitable or private funding.

Although the majority of nurses remained private duty nurses, paid by their patients, public health nursing was growing, as hundreds of nurses were employed to make home visits and to supply health education and health screenings to mothers and infants. Under the leadership of M. Adelaide Nutting, the roles of nurses in the community led to the beginning of nursing education in a university: Teacher's College in Columbia University in New York City. The program, in 1910, was started with an endowment from wealthy female donors and was used to educate a small body of teacher-nurses to carry the theory and practice of physical welfare for children, as well as hygienic living practices, into private homes, schools, and communities (Christy, 1969).

Although this was a first for nursing, the reality of the situation led to a sense of divisiveness among nurses. Many of the nurse leaders and Columbia students were women who had private means of support and came from educated families, whereas the majority of nurses were women who were hospital trained, who had an opportunity to perform altruistic work, and who, at that same time, were able to be independent and self-supporting (Roberts, 1954). All things considered, it was the merger of support of the public citizens, private education, an endowment of financial support, and a societal need that created a window of opportunity for the beginning of higher education for nurses.

After the establishment of nursing education in one university, and licensure by all states in place by 1914, nurse leaders devoted their renewed efforts to the production of an educational report for nursing, comparable to the Flexner Report for medicine. Finally, the Rockefeller Foundation commissioned a national study of nursing education, which was published in 1923 and known as the Goldmark Report (“Nursing and Nursing Education in the U.S.,” 1923). Although it was as critical of nursing schools as Flexner was of medical schools, the desired impact of moving the standard for nursing education into the university did not occur. The vision and efforts of the leaders, by themselves, were not sufficient to create their desired policy change for nursing education. Without the overwhelming support of the public, business, or government, the site of nursing education did not change—the window of opportunity was not open.

Nurses and Hospitals

By the mid-20th century, the world was involved in a major war, World War II. Patriotism was rampant, and women left their homes to take jobs helping the war effort while the men were off to war in the South Pacific, Europe, and Africa. At the same time, the Army Nurse Corps needed nurses, and President Roosevelt considered a nurse draft. Instead, Congress took action and established the Cadet Nurse Corps within the Public Health Service, which provided education for nurses through hospital schools. The Corps granted scholarships and stipends to qualified applicants in exchange for providing military or other essential nursing services for the duration of the war. State-accredited nursing schools also were provided certain funds for the nurses’ education (Office of the Public Health Service Historian, n.d.), all in the name of patriotism.

Not only did the nurses serve when needed for the war effort, but also many of the nurses educated through the Cadet Nurse Corps went on to become the next generation of nurse leaders. There was strong support for these efforts. This was another example of how a societal need and public policy came together to change the face of nursing by recruiting and educating women who otherwise might not have become nurses—another window of opportunity was opened.

After World War II, research and scientific advances, such as the use of antibiotics, the control of many contagious diseases, and advanced diagnostic and surgical technology, became part of medical practice. With the nation's increased prosperity after the war, Americans had an opportunity to worry about their health and sought medical treatment to take advantage of the new resources available to physicians. At the same time, private foundations no longer invested large sums of money into universities and the creation of professional knowledge. However, the federal government was about to take up the slack with increased support for medicine and financially troubled hospitals.

The Hill-Burton Act of 1946 provided construction funds to community hospitals, which were gearing up to serve as the new workplace of physicians; the federal government also subsidized medical schools and medical education. However, the expansion of hospitals occurred at the same time the supply of nurses was dwindling. The Cadet Corps nurses left their positions and returned to the at-home life they had had before the war just as the demand for hospital nurses exploded.

With the government's help in building hospitals and third-party payment emerging for medical services, the hospitals were now in a position where they could hire nurses. However, registered nurses were in short supply. To meet this shortage, in 1951 a new kind of nursing education was designed for nurse "technicians." This associate degree from community or technical colleges was awarded to nurses in a 2-year program, with hospital nursing, not the community, as its focus. The intent of the designer of the associate degree program, Mildred Montag, was for a separate license for graduates from these programs (Montag, 1951). However, the state board examination for registered nurse licensure became the same for the associate's degree, the hospital diploma, and the university nurse with a bachelor's degree. Successful completion of this one examination allowed graduates to become a registered nurse (RN)—an example of the unintended consequences of a new educational policy.

Before long, the majority of all nurses, regardless of their education, were employed in hospitals. To foster medical care of the elderly,

the Medicare Enactment of 1965 awarded funds to hospitals that provided medical education; however, that public policy also had a provision to support hospital schools of nursing through the same source of funds—Graduate Medical Education dollars (Thies & Harper, 2004). This mechanism of payment continues today, as long as the hospital owns or, in some cases, affiliates with the school of nursing.

Graduate programs were developed in nursing during the 1950s and 1960s, again with the prodding of a new generation of nurse leaders. With an increased emphasis and interest in research, the programs became focused on specialty areas of practice to allow nurses to become experts in one particular area of practice as well as a functional area such as education or administration. To assist in the education and development of the nursing profession, the U.S. Nurse Training Act of 1964 provided a comprehensive financial package for school construction, plus faculty development, student grants, and loans (Dickson, 1993). The increased funding for nursing resulted in many capital improvements, as well as the education and development of nurse faculty and high-level administrators. Many of today's seasoned nurse leaders were able to take advantage of this new public policy—an example of how public policy indirectly has shaped nursing.

As health care became more organized, and schools and the public gradually came to rely on the federal government and their policies, politics entered the picture and formed the intersection of politics and public policy. A more recent example of a public policy that has had a major impact on nurses and their practices is the Balanced Budget Act of 1997, which reduced payments to states for Medicare and Medicaid patients. This act, along with the implementation of managed care, has devastated hospital finances and increased the work demands on nurses as hospitals pared their staff to make ends meet. This, too, represents how public policy, not of its own making, has had a major influence on nursing, which many believe was the impetus for the current nurse shortage—another example of an unintended consequence of a public policy.

Moving Toward a Scientific Base for Nursing

Nationwide, about one-third of nurse graduates who enter the workforce are graduates from a 4-year college or university. Nurses educated at the entry level receive a generalist education covering both hospital and community nursing. Although the percentage of graduates holding

a college degree in nursing has gradually increased over time, the bachelor's degree in nursing is required for entry into graduate school for the nurse who wants to practice as an advanced-practice nurse or a teacher of nurses.

About the same time as graduate schools expanded as a result of the Nurse Training Act of 1964, nursing theories and research were added to the curriculum. Numerous nurses developed theories of nursing, and the profession moved toward becoming scientific; indeed, even a beginning science of nursing was evolving. A milestone was reached when the first research journal, *Nursing Research*, began publication in 1952. The focus was on research about nursing students, and the reports were so sparse that one edition contained the entire dissertation of a recent graduate from Teachers College (personal communication with Harriet Werley, one of the first nurse researchers). Since then, other research-oriented journals have been published as opportunities increased for the dissemination of new knowledge.

In 1962 the federal government again came to the rescue by establishing the Nurse Scientist Training Grant programs, which continued into the 1970s and enabled the applicant to obtain a PhD in nursing and a cognate discipline. Nine universities implemented these programs, with the cognate disciplines of anthropology, biology, psychology, sociology, microbiology, anatomy, and physiology (Grace, 1978). Many of these graduates became scientific leaders and continue to mentor a new generation of nurses with PhDs in nursing. Nursing research, using ever more current scientific methods, has continued to grow, and some research has been able to create policy changes in clinical areas, particularly in the maternal child realm (e.g., see Brooten et al., 2005).

As an example of how nurses have been able to collaborate for change, to use their numbers and their knowledge, we turn to the policy example of the establishment of the National Institute of Nursing Research. Legislation was proposed in 1986 to establish a Center for Nursing Research. Initially, President Reagan vetoed the bill. However, the nursing profession managed to gain support by finding its voice, and the veto was overturned, creating the center within the National Institutes of Health. Later, in 1993, the center was awarded designation as an Institute of Nursing Research, a result of major action taken by the profession working together to create a window of opportunity.

In sum, over time we have identified some policy changes put forth by others that have affected nurses: the 1946 Hill-Burton Act expanding the U.S. hospital system and thereby increasing dramatically the

demand for nurses or the Balanced Budget Act of 1997 reducing funds for health care that placed additional workplace stress on nurses. On the other hand, nurses, through public awareness, have created some policy changes: for example, Lillian Wald demonstrated the value of nurses to the people of the community, and advances were made in public health. However, it is only recently that policy changes have occurred based on scientific data-driven research in the tradition of Nightingale, linking nurse characteristics and organizational variables to patient outcomes. Now we do have the human capital—nurse scientists—to take advantage of large numbers and the tenacity of nurses and most importantly the knowledge of nurses’ experiences from which to build our political expertise and network (Joel, this text, ch. 16).

WHERE DO WE GO FROM HERE? THE INTERSECTION OF POLITICS AND POLICY

With a context of how nurses came to this point in our scientific history, the question now turns to how we might better use the evidence we are developing to benefit our patients through policy changes for nurses and their work. This book is focused on the research to policy connection through all phases of the process: from the “how to” of gathering evidence to the “how to” of influencing policy.

Although this book is not designed for final answers, given that the policy courses of action are a work in progress, some useful insights can be gained from the expert contributions to this book. For example, Joel in chapter 16 cites the process of how a legislative bill becomes law and reminds us that three elements are necessary to create policy change at any level: numbers, tenacity, and knowledge. A good example of the use of these three concepts to collaborate and advocate for change can be found in the establishment of the National Institute for Nursing Research presented earlier. Clearly, our history has taught us that change can be made when policy change is fostered by a window of opportunity.

The concept of an open window of opportunity in this context was coined by John Kingdon (2003) and is used by Palumbo in chapter 17 as she describes the political policy efforts of Vermont nurses in obtaining funds to increase nurses and faculty in her state. In a similar vein, Gladwell (2002) emphasizes in his best-selling book, *The Tipping Point*,

that it takes three things to make ideas “sticky” or spread among others to affect change: the context, the message, and the messenger.

Let us now look at the idea of a window of opportunity from Kingdon (2003), which can provide the background for Gladwell’s theory. We can explore situations in which nurses may find a “window of opportunity” opening to present their evidence regarding the relationship of nurses’ care processes to patients’ safety and the quality of their health care outcomes. Further, one can then view the window of opportunity as the context and carefully investigate what is the message and who is the best messenger.

Kingdon’s Agenda Setting

The policy agenda is described by Kingdon as “the list of subjects to which government officials and those around them are paying serious attention” (Kingdon, 2003, p. vii). With demands by interest groups, the public, and influential individuals, policy making has a dynamic nature in which problems rise and fall from the government’s agenda in an unpredictable manner. Kingdon identifies three streams in policy making: the problem, policy alternatives, and political opportunities. Convergence or “coupling” of the three streams is often chaotic and unpredictable but allows the problem to move onto the policy agenda when the streams converge and a window of opportunity opens.

There are many reasons a problem stream converges with the policy stream to form public policy. Some proposals work better than others, and some rise and fall without any rhyme or reason and may never become a policy. Of the three streams, the political one is the most difficult to tame. As Kingdon stresses, experts generate an agenda, and politicians set the agenda. It is useful to analyze the windows and patterns of behavior in different policy arenas to determine which problems actually make it to the policy agenda. However, Kingdon also points out that the forces that drive the political stream may be different from those that drive the policy stream. Ideas float around and sometimes collide and become fused or go off in diffuse directions. Because there is no one right way to go, policy making can, indeed, be chaotic.

Kingdon (2003) also identifies the role of communities of specialists and the ideas they develop. Especially for our purposes here, communities of specialists can be the expert researchers who have the benefit of conversing with large numbers of other experts, the attribute of tenacity, and

the knowledge of the problem. These attributes can apply to a community of researchers who are coalesced around a particular problem, such as the work of nurses. According to Kingdon, there is then a long period of “softening up, ideas are floated, bills introduced, speeches are made, proposals are drafted, then amended in response to reaction and floated again” (p. 115). Moreover, of course, although politicians like ideas, the budget is always a consideration, and attention must be given to funding the idea.

However, Kingdon (2003) does stress that ideas can be powerful as a basis for policy change, even more so than aggressive lobbying, but interest groups and what he calls political entrepreneurs connect ideas together to reach the policy agenda for consideration. These entrepreneurs highlight “indicators” of a problem by sending out press releases, presenting hearing testimony, speeches, and other devices, and bringing problems into the personal experiences of important people by giving them a firsthand look at the effects of the problem. Interest groups generating feedback in the form of letters, visits to decision makers, and protest activities all push for one kind of a problem definition rather than another one—a major conceptual and political accomplishment.

Given Kingdon’s theoretical framework of policy making, is it possible that nurse researchers are communities of experts who can become political entrepreneurs? Can we build through collaboration “experts” who will share ideas, promote feedback, and excite interest groups as well as use their knowledge of health care, their large numbers, and their tenacity to work for health care change? Kingdon’s ideas were based on interviews and analysis with participants in the health care and transportation sectors. On the other hand, Gladwell (2002) developed his ideas by observations of people and ideas as those ideas grew into general acceptance, seemingly without an apparent plan, to create “stickiness” or sustainability. To compare the two theories of how knowledge spreads and raises to the level of a policy agenda, let us turn to the ways provided by Gladwell to legitimate ideas.

Gladwell’s Stickiness of Ideas

Since the first edition in 2000, *The Tipping Point* has spent years on the best-selling list, and it is no wonder. Gladwell clearly demonstrates how an idea can spread like a contagious disease, with the right message and the right messenger. Here, I would like to begin with his concluding remarks, which provide hope to us as to how we might use his concepts to enhance our goal of connecting research to policy, in order to improve

health care through changing the work of nurses: “Look at the world around you. It may seem like an immovable, implacable place. It is not. With the slightest push—in just the right place—it can be tipped,” concludes Gladwell (p. 259).

Using examples from the spread of Hush Puppies to Bernie Goetz and the reduction in crime in New York City, Gladwell informs the reader of how change comes about. He describes it in a similar way to Kingdon (2003), by stressing it is unpredictable and even chaotic. Moreover, similar to Kingdon’s concept of political entrepreneur, Gladwell stresses that the right person (the messenger) with the right message in the right context can bring an idea to the “tipping point,” when “little ideas can make a big difference.”

An example from Gladwell that is likely to resonate with you, the reader, is the example of a nurse who began a program designed to increase knowledge and awareness of diabetes and breast cancer in the black community of San Diego. For her grassroots movement, she selected black churches as her focus, but the results were disappointing. A few interested persons showed up, but she could not get her message to “tip.” She realized that she needed a different context in which to reach many more women.

She found the right context upon moving the program from the black churches to beauty salons, where women spent up to 8 hours having their hair braided—a perfect context in which to reach a tipping point. To make the effort as effective as possible, the nurse trained the stylists to present the information about breast cancer in a compelling manner, using conversational methods of communication. As Gladwell (2002) noted, “And how much easier is it to hang the hooks of knowledge on a story?” (p. 255). This is a keen example of how to do a lot with little and be successful in changing attitudes and, in this case, getting women to have mammograms and diabetes tests, by using the right context, the right message, and the right messenger.

We can learn and gain some hope from seriously considering Gladwell’s elements of change—context, message, messenger—as we search for ways to bring a strong idea based on a program of evidence to the agenda setting of politicians. Even more positive is the possibility of using these ideas at the clinical or educational institutional level to have an idea reach the tipping point to create a policy change resulting in quality care to patients. Let us now apply some of Kingdon’s concepts of the window of opportunity and Gladwell’s tipping point to connect evidence and policy to nurses and their work.

APPLYING KINGDON AND GLADWELL'S THEORIES TO POLICY CHANGE BY NURSES

One has only to turn to CNN news to hear information about the need for reform in health care, where problems abound: safety, quality, access, cost, and disparities in outcomes, for example. Certainly, the major problems of our dysfunctional health care system are rising to, and moving onto, the policy-setting agenda. However, solutions are generated, but no one solution seems to be the choice. However, what often is missing from the dialogue of ideas is the leadership of nurses in defining the policies that are changing nursing practice at the point of origin—the clinical setting and the educational setting. Further, there is no consensus among communities of nurse experts as to the important issues to address with research. Evidence is growing to support change in the education and practice of RNs; however, the perennial issues of “turf-dominance” prevent nurses from presenting a strong message with messengers solidified around an identifiable problem. Without this basic contextual issue resolved, it is unlikely that the window of opportunity will open or that an idea will tip.

However, now that we have some ideas about how policy changes occur, perhaps a critical mass of nurse researchers can come to agreement about a problem, the evidence needed to present a strong message, and who might be the best messenger. For example, we know the safety of patients in hospitals is a major concern; it came to the attention of the Institute of Medicine (2000), who reported that as many as 98,000 Americans each year lose their lives needlessly in hospitals because of medical errors. As a result, numerous safety measures have been put into place through national recommendations—the accrediting bodies' requirement regarding the use of the traditional abbreviations not be used, clear labeling of medications that look-alike or sound-alike, and the reconciliation of patient pre-admission medications with their discharge medications, to name a few. Also as a result, nurses became the “doers” in seeing that physicians abide by these changes in mandated policies. Especially now, when nurses are in short supply, could we not demonstrate with evidence that this is a poor use of nurses' time and may have an impact on the quality of patient care and outcomes?

Additionally, there is evidence to suggest that the educational preparation of nurses has a relationship to patient outcomes, including mortality of and failure to rescue surgical patients (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). Could not the community of experts leading this

research be brought together to expand the research in a systematic, logical way, across settings, so that strong evidence can be presented regarding the educational preparation of nurses and the impact on patient outcomes? Given the focus on health care safety, “Look at the world around you. It may seem like an immovable, implacable place. It is not. With the slightest push—in just the right place—it can be tipped” (Gladwell, 2002, p. 259). Is it not possible to develop a carefully orchestrated campaign to spread the idea and bring it to the attention of policy-makers?

CONCLUSION

Quality in health care is a major problem, and registered nurses are the largest professional health care workforce. Can we not use our large numbers, our tenacity, and our evidence to bring about health care policy changes for the betterment of our citizens? What would it take? How could we build on our auspicious research beginnings? These are all questions for you, for me, and for us, as we consider some of the ideas put forth here and develop answers. Let us consider the principles of taking action as the window of opportunity opens and the ideas reach their “tipping point.” As we move toward our future, we can look back and remember Nightingale and her use of evidence to support policy change. As this chapter closes, consider that evidence suggests the current health care system is changing, and according to O’Neil (1998), the emerging health care system has an ongoing commitment to research and improvement. He suggests, “It might be more important for a profession to control and advance its research agenda than to control its scope of its practice in traditional ways. In fact, one could argue that the future control of scopes of practice will be a function of research in outcomes, not the actions of legislators” (p. 221). It is time to equip yourself for the challenge!

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